Journal of Intercultural Management and Ethics

JIME

ISSN 2601 - 5749, ISSN-L 2601 - 5749

published by

Center for Socio-Economic Studies and Multiculturalism
Iasi, Romania
www.csesm.org

TABLE OF CONTENT

Editorial……………………………………………………………………………………….3
Liviu Warter

Difference or Defect? Disability Considered in the Context of Transhumanism......................5
Sana Loue, Harshita Kuna, Sean Eli McCormick

Global Citizen 2.0: Transhumanism and Collective Identity …………………..…..………..13
Thomas R. Brooks, Stephen Reysen, Iva Katzarska-Miller

The Minimum Wage: A Barrier to Employment ..…………………………….……….…29
Emmanuel Asprodites, Walter E. Block

Modeling Political Instability: Political Culture, Governance, and Regional Relations in 161 Countries …………………………..……………………………………………………..45
Silviu-Petru Grecu

The Fatal Flaw of Balaam: When Prophecy Meets Profit……………………………...….61
Hershey H. Friedman, Linda W. Friedman

The Geographic Religion of Contraceptives …..…………….……………………..…...………...69
Anastasia Vînagă

THE GEOGRAPHIC RELIGION OF CONTRACEPTIVES

Anastasia Vînagă
„Grigore T. Popa" University of Medicine and Pharmacy, Iasi, Romania
E-mail: anastasia.vinaga@aegee.eu

Abstract

The impact of religion on the use of contraceptives is complex and multifaceted. It involves theological considerations, ethical frameworks, cultural norms, and individual beliefs within the context of each religious tradition. As societies evolve and scientific understanding advances, religious perspectives on contraception may also adapt and change over time. Birth control has been used since ancient times, but effective and safe methods of birth control only became available in the 20th century. Some cultures limit or discourage access to birth control because they consider it to be morally, religiously, or politically undesirable.

The intersection of religious beliefs and attitudes towards contraception raises profound ethical, theological, and social questions that continue to shape both individual choices and public policy debates. Religions, with their diverse doctrines and teachings, play a crucial role in shaping attitudes towards contraceptives. Many major world religions, such as Christianity, Islam, Judaism, Hinduism, and Buddhism, have traditionally held varying views on the use of contraceptives. Despite the availability of various contraceptive methods, there are still disparities in contraceptive use across different regions and communities worldwide.

Experiences of contraceptive counseling and obtaining contraceptives vary for women of childbearing age based on education level, race, ethnicity, and health insurance. Community pharmacists are playing a greater role in providing women with better access to contraceptives; as of June 2023, 19 states have direct pharmacy access policies that allow pharmacists to prescribe contraceptives. Additionally, in July 2023, the FDA approved an over-the-counter contraceptive pill that women will be able to purchase at pharmacies as early as 2024.

This article outlines the ethical considerations in contraceptive use within the religious setting at the intersection of science, conscience, diverse beliefs, public health and individual autonomy. As societies evolve, dialogue and collaboration between religious leaders, policymakers, health care providers, and communities is essential to foster understanding, address disparities, and advance reproductive justice for all.

Key words: Religion, Morality, Contraceptives, Health, Birth control

Introduction

The impact of religion on the use of contraceptives is complex and multifaceted. It involves theological considerations, ethical frameworks, cultural norms, and individual beliefs within the context of each religious tradition. As societies evolve and scientific understanding advances, religious perspectives on contraception may also adapt and change over time.

If the current rate of growth is maintained, the world's population will double in the next 40 years? And that if all the edible resources of the Earth were used to feed the people, they could support the existence of only 15 billion of us. A new expression has entered the language that describes the contemporary social demographic phenomenon: *carrying*

capacity. This concept defines the total number of inhabitants who can live on Earth at the same time - 15 billion (Hartvigsen, 2017, pp. 1-3).

Over the past three decades, the United States has seen dramatic declines in teen pregnancy and teen births. The teen birth rate was at its peak in 1991 with 61.8/1,000 15-19-year-old females. By 2020, the birth rate had dropped to 15.4/1,000 15-19-year-old females. This is an important public health success because the large majority of teen births are unplanned and undesired, and they have substantial impact on the individual, family and societal levels. Declines in teen birth have been seen across all racial and ethnic groups. However, disparities remain; Hispanic and non-Hispanic Black teens continue to experience a birth rate that is twice that of white teens. More than race and ethnicity, the teen birth rate is associated with social determinants of health and socioeconomic factors, as both predictors and outcomes (Osterman et al., 2022). Some of the early decline in teen birth rate can be attributed to delay in initiation of sexual activity. However, a majority of the decline through 2002 and nearly all of the decline thereafter has been attributed to increased contraceptive use and use of more effective contraceptive methods. Some national surveys provide high-level information on contraceptive use by adolescents (Martinez & Abma, 2020).

Birth control has been used since ancient times, but effective and safe methods of birth control only became available in the 20th century. Some cultures limit or discourage access to birth control because they consider it to be morally, religiously, or politically undesirable. High-quality contraceptive education has been shown to improve uptake of contraception, including among low-income patients. Experiences of contraceptive counseling are not uniform for women of all demographic backgrounds, nor is access to contraception. Women who are of racial or ethnic minority groups, sexual minority groups, and who are socioeconomically disadvantaged, have less access to adequate reproductive care and are less likely to use their preferred and potentially more effective methods of contraception (Dehlendorf et al., 2014). Contraceptive counseling is an important part of women's healthcare, not only to prevent unwanted pregnancy, but also to manage health issues such as migraines and acne as of June 2023, 19 states have direct pharmacy access policies that allow pharmacists to prescribe contraceptives.

History of contraception

Religion and contraceptives have been intertwined in a complex and often contentious relationship throughout history and across various cultural contexts. The Egyptian Ebers Papyrus from 1550 (Before Christ) BC and the Kahun Papyrus from 1850 BC have within them some of the earliest documented descriptions of birth control: the use of honey, acacia leaves and lint to be placed in the vagina to block sperm. Silphium, a species of giant fennel native to north Africa, may have been used as birth control in ancient Greece and the ancient Near East (Darroch & Singh, 2013). Due to its supposed desirability, by the first century AD, it had become so rare that it was worth more than its weight in silver and, by late antiquity, it was fully extinct. Most methods of birth control used in antiquity were probably ineffective (Cuomo, 2010, pp.121–126).

The ancient Greek philosopher Aristotle (c. 384–322 BC) recommended applying cedar oil to the womb before intercourse, a method which was probably only effective on occasion. A Hippocratic text On the Nature of Women recommended that a woman drink a copper salt dissolved in water, which it claimed would prevent pregnancy for a year (Totelin, 2009, pp.158–161). This method was not only ineffective, but also dangerous, as the later medical writer Soranus of Ephesus (c. 98–138 AD) pointed out. Soranus attempted to list reliable methods of birth control based on rational principles. He rejected the use of superstition and amulets and instead prescribed mechanical methods such as vaginal plugs and pessaries using wool as a base covered in oils or other

gummy substances. Many of Soranus's methods were probably also ineffective (Darroch & Singh, 2013, pp. 1756–1762).

In medieval Europe, any effort to halt pregnancy was deemed immoral by the Catholic Church, although it is believed that women of the time still used a number of birth control measures, such as coitus interruptus and inserting lily root and rue into the vagina. The oldest condoms discovered to date were recovered in the ruins of Dudley Castle in England, and are dated back to 1640. They were made of animal gut, and were most likely used to prevent the spread of sexually transmitted infections during the English Civil War. Casanova, living in 18th-century Italy, described the use of a lambskin covering to prevent pregnancy; however, condoms only became widely available in the 20th century (Knowles, 2012).

The birth control movement developed during the 19th and early 20th centuries. The Malthusian League, based on the ideas of Thomas Malthus, was established in 1877 in the United Kingdom to educate the public about the importance of family planning and to advocate for getting rid of penalties for promoting birth control. It was founded during the "Knowlton trial" of Annie Besant and Charles Bradlaugh, who were prosecuted for publishing on various methods of birth control (Cuomo, 2010, pp.121–126).

In 2010, the United Nations launched the Every Woman Every Child movement to assess the progress toward meeting women's contraceptive needs. The initiative has set a goal of increasing the number of users of modern birth control by 120 million women in the world's 69 poorest countries by 2020. Additionally, they aim to eradicate discrimination against girls and young women who seek contraceptives. The American Congress of Obstetricians and Gynecologists (ACOG) recommended in 2014 that oral birth control pills should be over the counter medications (Cottingham et al., 2012).

Currently, the FDA has approved in the US in 2023 the first oral contraceptive (norgestrel) for non-prescription use. The approval of this progestin-only oral contraceptive pill (Opill) gives patients the option to purchase oral contraceptive medications without a prescription at pharmacies, convenience stores, and grocery stores, as well as online (Food and Drug Administration, 2023).

Morality of Contraceptives

The intersection of religious beliefs and attitudes towards contraception raises profound ethical, theological, and social questions that continue to shape both individual choices and public policy debates. Religions, with their diverse doctrines and teachings, play a crucial role in shaping attitudes towards contraceptives. Many major world religions, such as Christianity, Islam, Judaism, Hinduism, and Buddhism, have traditionally held varying views on the use of contraceptives. These views are often rooted in interpretations of sacred texts, moral principles, and theological doctrines.

Christianity, for instance, exhibits a spectrum of perspectives. Roman Catholicism, guided by teachings such as those in Humanae Vitae, opposes artificial contraceptives while promoting natural family planning methods. Protestant denominations generally allow for a wider range of views, with some endorsing contraception as a responsible family planning tool. In Islam, interpretations of the Quran and Hadiths have led to diverse opinions among scholars and adherents regarding the permissibility and methods of contraception

The term ‘contraceptive’ includes anything that deliberately prevents conception or impregnation, including condoms, birth control pills, intrauterine methods, and barrier methods (Miriam-Webster, 2013). The morality of contraception largely hinges on the belief of when personhood begins. Throughout history, religious, scientific, and philosophical ideas surrounding the beginning of personhood have created dissention about the moment when a human being becomes a person. This debate has been especially important among Christians,

and opposing views have further separated Roman Catholics and Protestant Evangelicals. One view of personhood, largely endorsed by the Roman Catholic magisterium, is that personhood begins at the moment when God thinks of the being. Supporters of this view use Psalm 139 and Ephesians 1 as a basis. For example, Psalm 139:13-16 says that God knew David when he was “being made in secret” and when he was an “unformed substance”. The first commandment given to man was: "Be fruitful and multiply, fill the earth and subdue it" (Genesis 1:28). This indication constitutes a first reason for sexuality.

One of the most prominent voices against contraception comes from the Catholic encyclical Humanae Vitae, a theological document given by Pope Paul VI in 1968. The Humanae Vitae focuses on the principles that define marriage and the responsible use of those principles (Massa, 2010). These include: duties toward God, towards marriage, toward the people themselves, and toward society. The main duty owed God is to respect his purpose for marriage and the act of sex. According to the Humanae Vitae, sex is a sacred marital act, intended as an act of procreation. To use sex for any other means than procreation is to ignore God’s will for marriage (Bromberg, 2007). When a couple uses contraception, according to the Catholic Church, they are interfering with God’s will for marriage, as well as His plan for a person to be conceived and born. In fact, following the publication of Humanae Vitae, Catholic French bishops asserted that contraception can never be good (Parkinson, 2013). Contraception works in direct defiance of the actualization of the person that God had in mind. Pope Paul VI had suggested that couples who did not wish to become pregnant should refrain from sex during the infertile time of the month. This birth control method is often called the “calendar” or “rhythm” method. This would not be considered going against God’s will for sex because it is a natural way of preventing pregnancy (Murphy, 2011).

Religions vary widely in their views of the ethics of birth control. The Roman Catholic Church reaffirmed its teachings in 1968 that only natural family planning is permissible, although large numbers of Catholics in developed countries accept and use modern methods of birth control (ACGOG, 2014). The Greek Orthodox Church admits a possible exception to its traditional teaching forbidding the use of artificial contraception, if used within marriage for certain purposes, including the spacing of births. Among Protestants, there is a wide range of views from supporting none, such as in the Quiverfull movement, to allowing all methods of birth control. Views in Judaism range from the stricter Orthodox sect, which prohibits all methods of birth control, to the more relaxed Reform sect, which allows most. Hindus may use both natural and modern contraceptives. A common Buddhist view is that preventing conception is acceptable, while intervening after conception has occurred is not. In Islam, contraceptives are allowed if they do not threaten health, although their use is discouraged by some (Jana Marguerite Bennett, 2008, p.178).

Despite the availability of various contraceptive methods, there are still disparities in contraceptive use across different regions and communities worldwide. In South Asia, including India, the use of modern contraceptives is relatively low, and traditional methods such as withdrawal and periodic abstinence are still prevalent (de Vargas Nunes Coll et al., 2019). Limited access to contraceptives, inadequate knowledge, cultural and religious beliefs, gender inequality, and social norms are found to have a profound influence on contraceptive use in India Overall, the awareness and use of contraceptive methods are poor among the tribes. Only 46 % of Odisha's tribal women use modern contraceptive methods. Among the Santal and Lodha tribes, the knowledge of modern contraceptive methods is not universal, though the knowledge of sterilization is widespread. The gender difference is also prevalent in the type of contraceptive use among tribal communities; females' use of permanent methods is higher than that of males. Poor economic conditions and associated financial incentives are essential in influencing contraceptive use among the tribes in the Midnapore district of West Bengal (Basu S et al., 2004). Lack of proper knowledge about sterilization,

fear of side effects, fear of being sterilized, and perceived inability to work after sterilization are reasons for the non-use of contraception among tribal women in Madhya Pradesh. Apprehension of side effects and spouse disapproval are two significant reasons for never using contraceptives among the tribes in the Paschim Bardhaman district of West Bengal. The cultural practice of banning acceptors from worshiping God and fear of being unable to provide sexual satisfaction to their partner, which may cause remarriage of their spouse, is the most prevalent barrier to permanent family planning methods among tribal women in Odisha (Roy et al., 2021). Illiteracy, marriage below 18, younger age, and non-exposure to mass media are significantly associated with the non-use of contraception (Mudi & Pradhan, 2023).

The influence of medical workers' beliefs in the release of contraceptives

Experiences of contraceptive counseling and obtaining contraceptives vary for women of childbearing age based on education level, race, ethnicity, and health insurance. Community pharmacists are playing a greater role in providing women with better access to contraceptives; as of June 2023, 19 states have direct pharmacy access policies that allow pharmacists to prescribe contraceptives. Additionally, in July 2023, the FDA approved an over-the-counter contraceptive pill that women will be able to purchase at pharmacies as early as 2024. Inequities exist in access to contraceptive care for women of diverse backgrounds as well as those insured through Medicaid. State-level policy advancements and over the counter access to oral contraceptives may provide pharmacists a unique opportunity to provide contraceptive care for women without access to a primary care provider (Abrams & Look, 2023).

At least 23 states have passed laws or are considering measures, some that would grant pharmacists the right to refuse to fill morning after pill prescriptions, some to require pharmacists to dispense them without delay, and some to make them more accessible by requiring hospitals to offer them to rape victims or allowing pharmacists to sell them without a prescription. Of course, opponents' primary objection to the morning after pill involves the abortion issue. They argue that despite the term "emergency contraception," the drug actually can have an abortifacient effect, claiming it sometimes works to prevent a fertilized egg from implanting in the womb, about a week after conception. Indeed, the drug's labeling cites implantation prevention as one of the mechanisms by which the pill works.

To abortion foes, the push for easier access to such a drug is part of a strategy to make abortion more acceptable by making it more commonplace. "The push for easier access to the morning after pill continues a disturbing trend that started with artificial contraception," says Richard Doerflinger, deputy director of pro-life activities for the US Conference of Catholic Bishops. "To advance lifestyle goals, doctors now give drugs that make a healthy bodily system stop working."

Some pharmacists respond that they have no desire to ban the morning after pill; they just should not have to fill prescriptions that violate their view of the Hippocratic Oath. The position is supported by at least 45 state laws and most pharmacist organizations, including the Washington-based American Pharmacist Association, as long as the pharmacy puts in place a system to ensure that patients have access to legally prescribed therapy, either there or at another nearby pharmacy. Polls show little tolerance for conscientious objection. In late 2004, a CBS/New York Times poll asked, "Should pharmacists who personally oppose birth control for religious reasons be able to refuse to sell birth control pills to women who have a prescription for them?" Sixteen percent of respondents said yes and 78% said no. And an online poll by Medscape.com in the summer of 2005 found that 22% of respondents said pharmacists "should refuse to fill prescriptions that conflict with their personal beliefs." "The conscientious objector compromise works as long as long as it's truly followed," says Alta

Charo, a professor of law and bioethics at the University of Wisconsin who alleged in the New England Journal of Medicine last year that such health care providers seek only to protect themselves from the consequences of their actions, not their patients (Ackerman, 2006).

Research on person-centered contraceptive care (PCCC) has overlooked the role of the patient's religious affiliation. A study found that Catholic and Protestant women were more likely to report excellent PCCC compared to religiously unaffiliated and other religious women, suggesting the relevance of religious affiliation to experiences of person-centered contraceptive care. For researchers and clinicians, these findings have implications for improving patient outcomes, reducing provider bias in patient-provider encounters, and better understanding disparities in family planning care (Brewer & Clifton, 2023).

Conclusions

The ethical considerations surrounding contraceptives within religious frameworks often revolve around beliefs regarding the sanctity of life, the nature of marriage, and procreation. For instance, some religious traditions emphasize the procreative purpose of sexual relations within marriage and view contraception as potentially interfering with divine intentions. Others prioritize the well-being of families, women's health, and responsible parenthood, viewing contraception as a means to achieve these ends.

Moreover, the availability and use of contraceptives have significant implications for public health, gender equality, and socio-economic development. Access to contraceptives empowers individuals, particularly women, to make informed decisions about their reproductive health, education, and economic participation. In contrast, restrictions on contraceptive use based on religious beliefs can limit access to essential healthcare services, contributing to unintended pregnancies, maternal health risks, and population growth challenges.

The relationship between religion and contraceptives is multifaceted, reflecting deep-seated beliefs, ethical considerations, and practical implications for individuals and societies. Navigating this intersection requires a nuanced understanding of religious teachings, respect for diverse beliefs, and a commitment to promoting public health and individual autonomy. As societies evolve, dialogue and collaboration among religious leaders, policymakers, healthcare providers, and communities are essential to foster understanding, address disparities, and promote reproductive justice for all.

References

Abrams, L. M., & Look, K. A. (2023). Community pharmacists and improving contraception access: Relationships between contraceptive counseling and dispensing contraceptives. *Research in Social and Administrative Pharmacy*, *19*(12), 1602–1605. https://doi.org/10.1016/j.sapharm.2023.09.004.

Ackerman, T. (2006). Emergency contraception: Science and religion collide. *Annals of Emergency Medicine*, *47*(2), 154–156. https://doi.org/10.1016/j.annemergmed.2005.12.016.

ACOG Statement on OTC Access to Contraception. (2014). http://www.acog.org/About-ACOG/News-Room/News-Releases/2014/ACOG-Statement-on-OTC-Access-to-Contraception

Basu S, Kapoor Ak, & Basu Sk. (2004). Knowledge attitude and practice of family planning among tribals. *Journal of Family Welfare*, *50*(1).

Jana Marguerite Bennett. (2008). *Water Is Thicker than Blood*. Oxford University Press.

Brewer, M., & Clifton, T. (2023). Religious affiliation and women's receipt of person-centered contraceptive care: Findings from the National Survey of Family Growth,

2017–2019. *Contraception*, *127*, 110097. https://doi.org/10.1016/j.contraception.2023.110097.

Bromberg, H. (2007). *Humanae vitae*. Masterplots II: Christian Literature, 1-2.

Cottingham, J., Germain, A., & Hunt, P. (2012). Use of human rights to meet the unmet need for family planning. *The Lancet*, *380*(9837), 172–180. https://doi.org/10.1016/s0140-6736(12)60732-6.

Cuomo, A. (2010). *Encyclopedia of motherhood*. Sage Publications.

Darroch, J. E., & Singh, S. (2013). Trends in contraceptive need and use in developing countries in 2003, 2008, and 2012: an analysis of national surveys. *Lancet (London, England)*, *381*(9879), 1756–1762. https://doi.org/10.1016/S0140-6736(13)60597-8.

Dehlendorf, C., Krajewski, C., & Borrero, S. (2014). Contraceptive Counseling. *Clinical Obstetrics and Gynecology*, *57*(4), 659–673. https://doi.org/10.1097/grf.0000000000000059.

de Vargas Nunes Coll, C., Ewerling, F., Hellwig, F., & de Barros, A. J. D. (2019). Contraception in adolescence: the influence of parity and marital status on contraceptive use in 73 low-and middle-income countries. *Reproductive Health*, *16*. https://doi.org/10.1186/s12978-019-0686-9.

Hartvigsen, G. (2017). *Carrying Capacity, Concept of* Reference Module in Life Sciences*. Elsevier.

Knowles, J. (2012). A History of Birth Control Methods. *Planned Parenthood Report*.

Martinez, G. M., & Abma, J. C. (2020). Sexual Activity and Contraceptive Use Among Teenagers Aged 15-19 in the United States, 2015-2017. *NCHS Data Brief*, *366*, 1–8.

Massa, M.S. (2010). *Humanae Vitae in the United States*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199734122.003.0003

Merriam-Webster. (2013). Contraception. In *Merriam-Webster.com dictionary*. Retrieved January 4, 2025, from http://www.merriam-webster.com/dictionary/contraception

Mudi, P. K., & Pradhan, M. R. (2023). Attitude and determinants of contraceptive use among the Juang tribe: A cross-sectional study in Odisha, India. *Clinical Epidemiology and Global Health*, *24*, 101448. https://doi.org/10.1016/j.cegh.2023.101448

Murphy, W. F. (2011). Revisiting Contraception: An Integrated Approach in Light of the Renewal of Thomistic Virtue Ethics. *Theological Studies*, *72*(4), 812–847. https://doi.org/10.1177/004056391107200406.

Osterman, M.J.K., Hamilton, B.E., Martin, J.A., et al. (2022). Births: Final data for 2020. *Natl Vital Stat Rep*, 70, 1-50.

Parkinson, J. (2013). Humanae vitae II: Conscience, contraception and holy communion. *Australasian Catholic Record*, *90*(3), 297.

Roy, S., Mukherjee, A., Banerjee, N., Naskar, S., Das, D., & Mandal, S. (2021). Contraceptive behavior and unmet need among the tribal married women aged 15–49 years: A cross-sectional study in a community development block of paschim Bardhaman District, West Bengal. *Indian Journal of Public Health*, *65*(2), 159. https://doi.org/10.4103/ijph.ijph_115_21

Totelin, L.M. (2009). *Hippocratic Recipes: Oral and Written Transmission of Pharmacological Knowledge in Fifth- and Fourth-Century Greece*. Brill.